



Department of Health
Office of Emergency Medical & Trauma Prevention



**SERVICE / VEHICLE LICENSURE AND
TRAUMA VERIFICATION APPLICATION**

Service Name: _____ / _____
(Legal Name) (Also Known As)

Address: _____ EMS Agency/License #: _____
(If known)

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

EMS Representative: _____ Phone: _____

E-Mail Address: _____ FAX: _____

TRAUMA VERIFICATION REQUESTED? Yes ☐ No ☐

TYPE OF SERVICE (choose one only): Ambulance (Transport) ☐ Aid Service (Non Transport) ☐

LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

ORGANIZATION TYPE: (check the one that *best* applies to your organization)

Private for profit	<input type="checkbox"/>	Fire District	<input type="checkbox"/>	Law Enforcement	<input type="checkbox"/>
Private non-profit	<input type="checkbox"/>	City Fire Dept.	<input type="checkbox"/>	Municipal (city/county)	<input type="checkbox"/>
Private volunteer association	<input type="checkbox"/>	Industrial Fire Dept.	<input type="checkbox"/>	Search & Rescue	<input type="checkbox"/>
Hospital District	<input type="checkbox"/>	City/Fire Dist. Comb	<input type="checkbox"/>	Other (please specify below)	<input type="checkbox"/>
EMS District	<input type="checkbox"/>	Federal Fire Dept.	<input type="checkbox"/>		

VEHICLES: Please provide the **number** of each vehicle type you are licensing (see page 2):

Ambulance (Transport) Aid Vehicle (Non-Transport)

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year (if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information):

Primary Responses	<input type="text"/>	Transports Primary/Secondary	<input type="text"/>
Secondary Responses	<input type="text"/>	Interfacility Transports <i>Only</i>	<input type="text"/>

PERSONNEL STATUS: Are your EMS personnel primarily: (check one) Paid ☐ Volunteer ☐

Number of EMS personnel (page 3) that are: Paid Volunteer

DO NOT DUPLICATE

SERVICE / VEHICLE LICENSURE AND TRAUMA VERIFICATION APPLICATION EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all vehicles to be licensed. Vehicle location is the **address** in which the vehicle is **physically located**. Indicate the *type* of vehicle(s): AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030 and consistent with 70.168). **Please check to see that each licensed vehicle has a license sticker appropriately displayed in the window. If there is no sticker, request one below.**

Please review WAC 246-976-260 through 390 to ensure your vehicles meet all requirements. WAC 246-976-300 requires all licensed vehicles to carry extrication equipment. A variance from this requirement may be requested, and if approved, the extrication equipment must be available within 10 minutes. To request a variance, indicate the **name** of the agency(s) providing extrication equipment below and enter 'Yes' next to the appropriate vehicles.

YOUR SERVICE NAME: _____

Agency(s) providing extrication equipment: _____

YEAR	MAKE AND MODEL	LICENSE PLATE NUMBER	ACTUAL ADDRESS OF VEHICLE (If Different From Page 1)	Choose One (✓)		STICKER NEEDED (Yes or No)	VARIANCE For Extrication Equipment (Yes or No)
				AMB	AID		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Attach additional sheets as necessary, including all the required information.

NOTE: When *adding, removing, or changing* the location of licensed vehicles, it is always necessary to notify the Department of Health of the change(s). Contact the appropriate licensing office, at the address or telephone number below, to request a **“VEHICLE CHANGES APPLICATION.”**

DO NOT DUPLICATE

SERVICE / VEHICLE LICENSURE AND TRAUMA VERIFICATION APPLICATION EMERGENCY MEDICAL *PERSONNEL*

List all medical personnel in your organization who are providing emergency care, aid or transportation, and check the appropriate column(s). Include personnel who are full or part-time, paid or unpaid.

PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.

SERVICE NAME: _____

NAME (LAST, FIRST, M.I.)		EMT	IV TECH H	AW TECH	IV/AW TECH	ILS TECH H	LS/AW TECH	PM	OTHER (Specify)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
PLEASE TOTAL EACH COLUMN:									

Attach additional sheets as necessary, including all the required information.

Legend:

EMT = Emergency Medical Technician

IV TECH = Intravenous Therapy

AW TECH = Airway Technician

IV/AW TECH = IV and Airway

ILS TECH = Intermediate Life Support

ILS/AW TECH = ILS & Airway

PM = Paramedic

OTHER = RN, MD, PA, Flight Nurse

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**SERVICE / VEHICLE LICENSURE AND
TRAUMA VERIFICATION APPLICATION
GENERAL OPERATION**

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. *(Please find this information on our website at www.doh.wa.gov/hsqa/emtp click on "Licensure Processes." If you need hard copies of this information, please contact the appropriate Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. Dispatch plan

2. Response plan

3. Response area

4. Type of transport (emergency and/or interfacility), if any

5. Tiered response and rendezvous, if any

6. Back-up plan to respond

NOTE: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach extra sheets as necessary.

"I hereby affirm and declare that the information provided on this application is true and correct, and that:

- 1. We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures;*
- 2. The vehicles identified on Page 2 meet the minimum equipment requirements for the level and type of trauma verification requested by our service;*
- 3. We meet the minimum staffing requirements for verification as identified on Page 3;*
- 4. Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
- 5. We maintain current liability insurance coverage (copy attached)."*

Person Completing Application

(Please Print)

Date

Owner/Operator

(Signature & Title)

Date

DO NOT DUPLICATE

**SERVICE / VEHICLE LICENSURE AND
TRAUMA VERIFICATION APPLICATION
REGIONAL COUNCIL REVIEW AND COMMENT**

Service Name: _____ **Phone:** _____

Address: _____

Contact Person: _____ **Date:** _____

TYPE OF SERVICE: Ambulance (Transport) ☐ Aid Service (Non Transport) ☐

LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

The signature below is required in accordance with WAC 246-976-390. Please note that only DOH may approve licensure and verification of services.

REGIONAL COUNCIL REVIEW AND COMMENT

Does this application for verification appear to be consistent with the Regional Plan?

Yes ☐

No ☐ Attach documentation to explain a "No" answer.

Regional EMS Council Representative (Print or Type)

EMS Region

Signature

Date

DO NOT DUPLICATE

OEMTP / L&C, PO BOX 47853, OLYMPIA, WASHINGTON 98504-7853 / (360) 236-2845 / 1-800-458-5281, Ext. #1